In the Supreme Court of the United States

October Term, 1976

No. 75-554

FRANK S. BEAL, Individually and as Secretary of the Department of Public Welfare, Commonwealth of Pennsylvania; ROGER CUTT, Individually and as Assistant Deputy Secretary for Medical Services, Commonwealth of Pennsylvania; GLENN JOHNSON, Individually and as Chief of the Bureau of Medical Assistance, Commonwealth of Pennsylvania; JAMES A. DORSEY, JR., Individually and as Executive Director of the Allegheny County Board of Assistance; and the DEPARTMENT OF PUBLIC WELFARE OF THE COMMONWEALTH OF PENNSYLVANIA,

Petitioners

vs.

ANN DOE; BETTY DOE, a Minor by Her Mother as Representative, MOTHER B. DOE; CATHY DOE; DONNA DOE, a Minor, by Her Mother as Representative, MOTHER D. DOE; ELAINE DOE; JANE DOE, a Minor by Her Father as Representative, FATHER J. DOE; NANCY DOE; PATRICIA DOE; RUTH DOE; SYLVIA DOE; and TONI DOE, Each Individually and on Behalf of All Other Women Similarly Situated,

Respondents

Certiorari to the United States Court of Appeals for the Third Circuit.

BRIEF FOR PETITIONERS

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CASES:

Burns v. Acala, 420 U.S. 575 (1975) 14, 15

OPINIONS BELOW

The majority and dissenting opinions of the District Court are reported at 376 F. Supp. 173, and are set out in the Appendix at 66a-114a. The majority and dissenting opinions of the Court of Appeals *en banc,* reported at 523 F.2d 611, are set out in the appendix at 126a-186a.*

JURISDICTION

The judgment of the Court of Appeals was entered on July 21, 1975, the Petition for Certiorari was filed on October 10, 1975 and certiorari was granted on July 6, 1976. The jurisdiction of this Court is invoked under 28 U.S.C.A. §1254(1).

* The decision of a panel of the court of appeals, not officially reported is set out in the Appendix at 117a-123a.

STATUTES AND REGULATIONS INVOLVED

The Social Security Act, Title XIX, §1902, as added July 30, 1965, Pub. L. 89-97, 79 Stat. 344, 42 U.S.C.A. §§1396 and 1396(a) are set out in the appendix to this brief at 24, infra.

The Pennsylvania General Medicaid Regulations, M. A. Man. §9100 are set out in the appendix to this brief at 52, infra.

QUESTION PRESENTED

Whether Title XIX of the Social Security Act requires that states, participating in the federal-state Medical Assistance Program, provide coverage for the costs of non-therapeutic abortion services.

STATEMENT OF THE CASE

In October of 1973 each of the respondents was pregnant and desired an abortion for non-medical reasons. Most of the women wished to avoid the inconvenience of child birth. Others wanted to terminate their pregnancies for financial reasons, and one of the respondents desired to avoid the interference a birth would have on her schooling (44a-65a).[1] However, all of these women, then eligible for medical assistance (medicaid),[2] were refused the desired medical services because they were unable to demonstrate that the services would be covered by medicaid.

Pennsylvania's medicaid program covers the reasonable costs of abortions that are medically necessary.[3] Un-

[1] From the affidavits it is apparent that two of the respondents may have qualified for therapeutic abortions: Cathy Doe referred to deteriorating medical conditions as a reason for desiring an abortion and Ann Doe mentioned "medical problems" as a reason for seeking an abortion. That being so, it is unclear why these women were not able to present the required documentation of medical need. Nevertheless, it is clear that the remaining nine desired abortions for reasons other than health. For example, Toni Doe and Nancy Doe each affirmatively stated that they did not seek their abortions ". . . for any of the purposes contained in the Department of Public Welfare procedures governing Medical Assistance coverage of abortions." (46a, 49a).

[2] Of the eleven individual respondents, six were then receiving Aid to Families with Dependent Children (AFDC) and five were receiving public assistance grants from the Commonwealth of Pennsylvania. (44a-65a).

[3] On September 25, 1975, as the result of the decision of the court of appeals in this case, and in accord therewith, a Temporary

der this program an abortion is deemed to be medically necessary if:

> (1) There is documented medical evidence that continuance of the pregnancy may threaten the health of the mother;
>
> (2) There is documented medical evidence that an infant may be born with incapacitating physical deformity or mental deficiency; or
>
> (3) There is documented medical evidence that continuance of a pregnancy resulting from legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of a patient; and
>
> (4) Two other physicians chosen because of their recognized professional competency have examined the patient and have concurred in writing;[4] and
>
> (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.[5]

On October 3, 1973, the respondents instituted this civil rights action seeking to compel the petitioners to extend medicaid coverage to the costs of non-therapeutic

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Revised Policy was instituted by the petitioners which allows payment for any abortion irrespective of its medical necessity (infra). This is purely an interim policy depending final deposition of this appeal.

[4] This requirement of two-doctor concurrence tracks the formal position of the Pennsylvania Medical Society (p. 79, infra).

[5] 3 Pennsylvania Bulletin, 2207, 2209 (Sept. 29, 1973), and Med. Soc. Policy, p. 79 infra.

abortions.[6] Their challenge to Pennsylvania's Medicaid regulations regarding abortions was predicated on two theories: first, that the regulations violated Title XIX of the Social Security Act;[7] and secondly that these restrictions denied the respondents equal protection of the laws in violation of the Fourteenth Amendment to the Constitution. On October 9, 1973 a preliminary injunction was issued requiring the Petitioners to reimburse the reasonable costs of these abortions.[8]

A three-judge court was convened pursuant to 28 U.S.C.A. §2281, and by majority opinion the district court concluded that Pennsylvania's medical necessity requirement, with respect to abortions, was consistent with Title XIX. However, the Court went on to find that this restriction violated the Equal Protection Clause[9] as applied during the first trimester of pregnancy.

Petitioners appealed to the court of appeals from this declaratory judgment, and the respondents cross-

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[6] The term "non-therapeutic abortion", as used in this brief, refers to any abortion performed for reasons unrelated to the health of the mother. A therapeutic abortion can be necessitated by physical as well as mental health considerations.

[7] The Social Security Act, Title XIX, §1902, as added July 30, 1965, Pub. L. 89-97, 79 Stat. 344, 42 U.S.C.A. §1396 *et seq.* Future references to this Act, Sections 1396 and 1396a of which are completely set out in the Appendix to this brief, will be to the United States Code Annotated, or simply to "the Act".

[8] Actually the injunction went beyond the individual plaintiffs, and enjoined enforcement of the abortion regulations throughout all of Allegheny County (60a).

[9] The opinion of the three-judge court, Circuit Judge Weiss dissenting, rendered on May 3, 1974, is set forth in the appendix at 67a-117a.

appealed from the denial of declaratory relief with respect to the second and third trimesters of pregnancy.[10] On July 21, 1975, the court of appeals *en banc,* with three judges dissenting, held that during the first two trimesters of pregnancy Pennyslvania's medical necessity requirement for abortions violated the requirements of Title XIX.[11] Having decided the case on statutory grounds the lower court properly did not address the constitutional question which was presented. *Hagans v. Lavine,* 415 U.S. 528 (1974). Petitioners sought, and were granted, a writ of certiorari from this Court to review that decision.[12]

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[10] The court of appeals' jurisdiction over this appeal was proper because the respondents did not appeal from the district court's refusal to award any injunctive relief. *Gerstein v. Coe,* 417 U.S. 279 (1974).

[11] The court of appeals' majority and dissenting opinions are fully set forth at 126a-185a. References to this opinion will be to both the Appendix and the reported opinion.

[12] The petition for a writ of certiorari was granted on July 6, 1976.

SUMMARY OF ARGUMENT

A. In Title XIX of the Social Security Act, Congress intended to give the states great latitude in the creation of their respective medicaid programs. Because of economic constraints, Pennsylvania has chosen to fund only the most critical medical services, and then only when those services are medically necessary to protect or maintain the recipient's health. This medical necessity requirement is not inconsistent with Title XIX, even when applied to abortions.

B. The lower court's holding in this case is contrary to the conclusion of every other circuit court that has addressed this question. The majority below erred by not considering Title XIX in its proper historical context. Notwithstanding this, its reasoning, that Congress did not intend to freeze the allowable services under Medicaid to those recognized in 1965—does not justify its conclusion that coverage for non-therapeutic abortions was made mandatory upon the states. This is especially true in view of the fact that such procedures were illegal in most states at the time Title XIX was enacted. Similarly, reasons which were found persuasive by other courts, such as other recent legislation disapproving abortions, and Congress's complete silence on the subject in Title XIX, should not have been ignored by the lower court. Finally, however characterized, the medical necessity requirement is applied uniformly throughout Pennsylvania's medicaid program and accordingly does not violate the equality provisions of Title XIX when applied to abortions.

ARGUMENT

A. Medicaid in Pennsylvania: An Overview

In 1965 Title XIX of the Social Security Act was enacted[13] establishing the national Medicaid program. The overall design of the program has been likened to a "scheme of cooperative federalism", *King v. Smith,* 392 U.S. 309, 316 (1968); *New York Dept. of Social Services v. Dublino,* 413 U.S. 405 (1972); 134a; 523 F.2d 611, 616. The Act grants states that elect to participate, great latitude in the creation of their respective programs. Accordingly, in Title XIX Congress delineated only the broad parameters of a federal-state program that would, ". . . as far as practical under the conditions in [each] state . . ." provide medical assistance to those ". . . whose income and resources are insufficient to meet the costs of necessary medical services . . ." 42 U.S.C.A. §1396. However, the actual make-up of each state program was, to a large extent, left to the states. For example, decisions as to precisely which services to provide, the rate of payment for those services, as well as the definition and determination of eligibility, were all generally to be made within each state. 42 U.S.C.A. §1396a(a)(17).

Of course, there are certain general federal guidelines which the programs must meet. For example, in order for

[13] 42 U.S.C.A. §1396 *et seq.*

a state to participate, its medicaid plan must provide services in each of the following general categories: (1) inpatient hospital services; (2) outpatient hospital services; (3) other laboratory and X-ray services; (4) skilled nursing facility services (as well as child health screening and treatment, and family planning services); and (5) general physicians services. 42 U.S.C.A. §1396a(a)(13)(B); 45 C.F.R. §§249.10(a)(1)(5). However, a state is not required to provide *every* service that may fall into each of these categories.[14]

Moreover, these five required medical services must be made equally available to all individuals who are "categorically" needy. 42 U.S.C.A. §1396a(a)(10)(A) and (B). The "categorically" needy group includes financially eligible families with dependent children as well as the aged, blind, and disabled. 42 U.S.C.A. §1396a(a)(10)(A); 45 C.F.R. §24810(1). A participating state is given the option to extend medicaid to poor persons who do not meet the "categorically" needy guidelines.[15] 42 U.S.C.A. §1396a(a)(10)(C). However, the state need not provide these individuals with services from each of the five required groups. 42 U.S.C.A. §1396a(a)(13)(C)(i), (ii),

[14] 42 U.S.C.A. §1396d(a) defines "medical assistance" as ". . . payment of part or all of the cost of [the above] services . . . ." See also 42 U.S.C.A. §1396a(a)(17) which allows the state to establish reasonable standards regarding ". . . the extent of medical assistance under the plan which . . . are consistent with the objectives of [Title XIX]."

[15] This group is referred to as the "medically" needy and it includes persons who have enough income and resources to render them ineligible for financial aid, but who are nevertheless unable to meet the costs of necessary medical expenses. See 62 Pa. Stat. Ann. §442.1; and 45 C.F.R. §§248.10(a)(2).

but the services that are provided may not exceed in ". . . amount, duration or scope . . ." the services that are provided to the "categorically" needy. 42 U.S.C.A. §1396a (a) (10) (13) (ii).[16]

Finally, each participating state must have a review mechanism to guard against the unnecessary utilization of medical services[17] in its program. While the Act contains many other options available to the states, this is the general program outline that Congress prescribed in Title XIX.

Pennsylvania's medicaid plan,[18] which was approved by the Secretary of Health, Education, and Welfare

[16] The types of medical services which are optional with the states are: medical care recognized under state law and furnished by licensed practitioners; home health care services; private nursing services; clinic services; dental services; physical therapy; prescribed drugs, dentures or devices, other diagnostic or screening services, prosthetic services for individuals 65 years of age or over institutionalized for mental disease or tuberculosis; intermediate care facility services; certain inpatient psychiatric care for individuals under age 21; any other medical or remedial care which may be specified by the Secretary. 42 U.S.C.A. §1396d(6)-(17); 45 C.F.R. 249.10(a)(6)-(17).

[17] 42 U.S.C.A. §1396a(a)(30) provides that a State plan must:

> Provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care.

[18] The general regulations for the plan have been included in the appendix to this brief at 52. It should be noted that

(HEW), represents an attempt to rationally and equitably distribute its very limited medicaid resources. The need for medical services is far greater than the Commonwealth can accommodate, and the pressure mounts every year because of the incessant rise in the cost of medical services.[19] Therefore, Pennsylvania was compelled to generally limit its medicaid program to cover only the most urgently needed medical services. Accordingly, many important medical services such as speech and physical therapy have been excluded from coverage under the program.

In any event, it is clear that under Title XIX a state may limit its medicaid program by not providing reimbursement for every recognized medical service.[20] With this in mind, and in view of the Commonwealth's financial constraints, Pennsylvania has limited the coverage of its medicaid program to those services which are medically necessary at the time of their utilization. For example, the services of a plastic surgeon are reimbursable under the program, however, these services will only be reim-

Pennsylvania's program covers both the categorically and medically needy—providing slightly different services to the latter group.

[19] Pennsylvania alone has seen its medical assistance expenditures more than double since 1970—from $150 million in 1970 to $324 million last year. Act of Feb. 9, 1971, P.L. 803, No. 1A; Act of Mar. 4, 1971, P.L. 809, No. 3A; Act of June 30, 1975, P.L. ——, No. 8A; Act of May 20, 1976, P.L. ——, No. 5A.

[20] See note 14, supra. In this respect, it is also noteworthy that the equality provisions contained in the Act would hardly have been necessary if Congress intended that all recognized medical services be covered in a state's medicaid program. 42 U.S.C.A. §1396a(a)(10)(B)(i)(ii).

bursed when they are rendered for medical reasons.[21] Similarly, only the most urgently needed dental services are covered by Pennsylvania's program. Services such as orthodontics and periodontics have been completely excluded from medicaid coverage in Pennsylvania.[22]

Thus, the touchstone of Pennsylvania's medicaid program is medical necessity,[23] and this requirement does not run afoul of Title XIX, even when it is applied to abortions. The unambiguous language of Title XIX describes its primary goal as meeting the costs of ". . . necessary medical services . . . ." 42 U.S.C.A. §1396. Nevertheless, the respondents contend, and the court of appeals held, that the medical necessity requirement, as applied to abortions, violates Title XIX of the Social Security Act.

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[21] The Pennsylvania Medical Assistance Manual (M. A. Man.) Section 9411. 213 provides:

> Payment is made for plastic surgery in connection with repair of accidental injury, the improvement of the functioning of a malformed body member, or for correction of a visible disfigurement which could materially affect the person's acceptance by society. Payment is not made for plastic surgery solely for cosmetic or beautifying purposes, such as rhenoplasty or mammoplasty.

[22] The General Medical Assistance Regulations Section 9100 Part II E 5 refers to the program's goal in this respect as ". . . provid[ing] adequate, but not extravagant or superfluous care . . ."

[23] The General Medical Assistance Regulations provide:

> ". . . the [medical assistance program] pays for those types of medical and allied services given in the home, office, clinic, or hospital, *that are generally recognized as necessary treatment of illnesses.*" (Emphasis added.) M. A. Man. §9100 E1.

B. Title XIX of the Social Security Act Does Not Require That a Participating State Provide Medicaid Funds for the Costs of Non-Therapeutic Abortions

The Solicitor General has disagreed with the court of appeals in an *amicus curiae* brief filed on behalf of HEW, taking the position that Title XIX does not require that states pay for non-therapeutic abortions as part of their medicaid programs.[24] Therefore, the question is whether or not HEW's construction of the Act is unreasonable. *Udall v. Tallman,* 380 U.S. 1, 16 (1964). The petitioners contend that this construction is reasonable and therefore should have been adopted by the Court of Appeals.

1. By its holding that Title XIX requires payment for nontherapeutic abortions, the lower court stands alone among the circuit courts which have addressed this issue. *Roe v. Norton,* 522 F.2d 928 (2nd Cir. 1975), cert. granted *sub nom. Maher v. Roe,* U.S. , 96 S.Ct. 3219; *Roe v. Ferguson,* 515 F.2d 279 (6th Cir. 1975); *Doe v. Rose,* 499 F.2d 1112 (10th Cir. 1974). In reaching its contrary result, the lower court rejected the reasons which the other circuit courts found compelling. For example, the majority found unpersuasive the fact that nontherapeutic abortions were illegal in most states in 1965 when Title XIX was enacted[25] 151-2a, 523 F.2d 622.

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[24] The court of appeals was, of course, aware of the views of HEW on this issue, but rejected them nonetheless. 146a n. 21a, 523 F.2d 620, 621 n. 22 (note 21a is numbered "22" in the bound edition of 523 F.2d.).

[25] In *Roe v. Wade,* 410 U.S. 113 (1973), at 118-9 n. 2 this Court noted that non-therapeutic abortions were completely illegal in more than 30 states at that time.

It is one thing to hold that as of 1965 Congress specifically prohibited or required Medicaid coverage for certain specific medical procedures. It is quite another matter to view the Act as having done neither but rather having left to the states the decision as to which services to cover and which not to cover. The latter is clearly the more flexible and reasonable view of this piece of social legislation.[29] More importantly this view is perfectly consistent with the language and purpose of Title XIX and avoids the awkward result of finding that Congress intended to require the states to fund a medical procedure that was a crime to perform in most of those states.

Similarly, the lower court was unimpressed by recent Congressional pronouncements on the subject of abortions. However, at least one other circuit court found this Congressional disapproval of abortion to be significant.[30] The

[29] The lower court correctly points out that Congress ". . . surely intended medicaid to pay for drugs not legally marketable . . . in 1965 which are subsequently found to be marketable" 152a, 523 F.2d 611, 623. However, this assumption only strengthens Pennsylvania's position. There is nothing in the construction advanced by the petitioners that would require reading Title XIX to preclude a state from constantly updating its inventory of allowable medical services. In fact quite the contrary is true—for just as petitioners assert that coverage for non-therapeutic abortions was not *required* by the Congress, so too do they recognize that such a procedure was not *precluded* from coverage under the Act.

[30] In *Roe v. Ferguson*, 515 F.2d 279 at 283 (6th Cir. 1975) on the basis of the prohibitions of federal funding for abortions contained in the Family Planning Services and Research Act of 1970, 84 Stat. 1508, 42 U.S.C.A. §300a, §§300a-6 as well as the Legal Services Corporation Act, 88 Stat. 383, 42 U.S.C.A. §§2996, 2996f (b)(8), the Court concluded that Congress would not mandate

majority below concluded that such an inference was unwarranted. Instead, the lower court found that Congress intended to require medicaid coverage for non-therapeutic abortions because it failed to clearly prohibit such coverage:

> "Congress could have proscribed payment for elective abortions [in title XIX] when it passed the Family Planning Services and Research Act of 1970, or in 1972 when it amended Title XIX, but it did not do so." 152a, 523 F.2d 611, 623.

It may be reasonable to infer from these Congressional actions on abortion, an intent to allow medicaid payments for non-therapeutic abortions—it is not reasonable however, to infer an intent to make such payments mandatory.

3. The lower court determined that a basic principle underlying Title XIX was that the physicians' discretion in prescribing the proper treatment for a given medical condition be free of "[g]ratuitious intereference", 149a, 523 F.2d 611, 621. According to the majority, once the state has determined that a medical condition requires medical treatment—"[t]he proper treatment of such a condition . . . must be left to the judgment of the attending physician" 146a, 523 F.2d 611, 620. Therefore, since Pennsylvania has determined that ". . . pregnancy is a condition for which medical treatment is 'necessary' " there is no basis in Title XIX ". . . for preventing an attending physician from choosing non-therapeutic abortion as the method for treating a pregnancy." Id. at 149a, 621.

Title XIX coverage for non-therapeutic abortion services *sub-silentio*.

This conclusion simply is not justified by its premise. Petitioners agree that an overriding concern of Congress in Title XIX was that states not interfere with the exercise of a physician's discretion. But certainly that discretion is not boundless. Physicians are trained to prescribe medical treatment for illnesses and other conditions which require medical attention. In the first instance, a physician is no more expert than a lay person in recommending non-therapeutic services—even if they are medical services. It is not part of the traditional role of a physician to recommend one life style over another, or the most economically sound means of providing for one's family. His role is to treat illness—not to provide social and economic counselling.

A physician is, no doubt, uniquely suited to determine if a desired medical procedure is medically feasible. For example, the decision to undergo purely beautifying cosmetic surgery normally would originate with the patient. And the reasons underlying such a decision would clearly not be medical. However, a physician would still be necessary to determine if the desired procedure is medically possible. But, even the lower court agreed that a state's medicaid program need not pay for every medical service that is feasible, 145a, 523 F.2d 611, 620. And when a woman decides to terminate her pregnancy for non-medical reasons the role of the physician is limited to deciding whether the procedure is medically feasible.

On the other hand when a physician recommends termination of a pregnancy for any medical reason, medicaid coverage is of course extended to pay the costs of that operation. It is entirely reasonable to require that a recommendation for treatment of any kind be predicated upon

the physician's evaluation of the patient's medical needs—as opposed to the patients social or economic needs. A physician is trained to advise on the proper treatment of medical needs, and interference with the exercise of his judgment in that regard would, in the words of the lower court, create a program of "medical obstruction" rather than medical assistance, 149a, 523 F.2d 611, 621. But the physician is not so uniquely qualified with respect to a patient's social and economic needs—and there appears to be no reason to accord his recommendations in those areas the same deference accorded his medical judgment with respect to the treatment of illnesses.

4. The lower court alternatively found that the petitioners' policy with respect to abortions violates section 1396a(a)(10)(B) and (C), 150a, 523 F.2d 611, 622.[31] The essential requirements of these complicated sections of the Act are that the coverage provided under a state plan may not be less in "amount, duration, and scope" for one categorically needy individual, as compared to another categorically needy individual,[32] or medically needy individual.[33] And, if it is provided at all, medical assistance must be equal among all medically needy individuals.[34]

The court of appeals reasoned that ". . . since the 'least voluntary method of treatment' requirement which the regulations impose on pregnant women is imposed on

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[31] This section of Title XIX is completely set out in the appendix to this brief at 27-29.

[32] 42 U.S.C.A. §§1396a(a)(10)(B)(i).

[33] 42 U.S.C.A. §§1396a(a)(10)(B)(ii).

[34] 42 U.S.C.A. §§1396a(a)(10)(C).

no other class of recipient",[35] those regulations violated the equality provisions of Title XIX described above. First, Pennsylvania's medicaid program provides equal benefits to all eligible recipients as is required by Title XIX—otherwise the plan could not have been approved by the Secretary of HEW. 42 U.S.C.A. §1396a (a) (10). All medical services must be medically necessary in order to qualify for medicaid reimbursement in Pennsylvania—and abortion is no exception. In lower court's view this medical necessity requirement, was characterized as ". . . 'the least voluntary method of treatment' requirement." 150a, 523 Fed. 2d 611, 622. And this requirement resulted in unequal services being provided pregnant women who desire to abort their pregnancies for purely non-medical reasons. However, if this were correct, then what of the needy person who desires cosmetic surgery purely for beautifying purposes when compared to a person who must undergo the same surgery for medical reasons? Medicaid coverage is extended to the latter and not the former—yet the lower court's analysis would clearly require coverage for both. However, such broad medicaid coverage, if allowed, surely is not mandated by Title XIX. Whether termed 'medical necessity' or, as the lower court would have it, 'least voluntary' this requirement is imposed equally upon all medicaid recipients in Pennsylvania.

5. This court has repeatedly admonished against interpretations of the Social Security Act that hinge on remote implications of Congressional intent. *Dandridge v. Williams,* 397 U.S. 471 (1970); *Jefferson v. Hackney,* 406 U.S. 535, 545 (1971). In *New York State Department of*

[35] 150a, 523 F.2d 611, 622.

Social Services v. Dublino, 413 U.S. 405 (1972) the Court reversed the holding of a lower court with respect to its broad interpretation of the Social Security Act. In refusing to accept the Congressional mandate inferred by the district court, this Court noted that it ". . . has repeatedly refused to void state statutory programs, absent congressional intent to pre-empt them". Id. at 413. Moreover, Mr. Justice Powell, for the Court, pointed out that the plaintiffs in that case had failed to show the required ". . . clear manifestation of congressional intention . . ." Ibid.

The Respondents' efforts in that respect have also missed the mark in this case. First, neither the respondents, nor the majority below, can point to any language in Title XIX or its legislative history that even mentions the subject of non-therapeutic abortions, much less requires that states fund them as part of their medicaid programs.[36] Secondly, the federal agency charged with administration of medicaid has taken the position that Title

[36] The respondents asserted in the lower court that coverage for non-therapeutic abortions was implicitly mandated as being either a "physicians' service", "inpatient service", "outpatient service", or a "family planning service". The lower court rejected these contentions. 144-5a, 523 F.2d 611, 620. The court noted that in order to adopt these views it would have to hold that all medical procedures legally within the practice of medicine were required to be covered by a state's medicaid program. As noted earlier, this view is inconsistent with the clear statutory language of title XIX. See e.g., 42 U.S.C.A. §1396, 42 U.S.C.A. §1396a(a)(17) and 45 C.F.R. 250.18 all of which explicitly recognize that states need not provide coverage for every conceivable medical service, but rather may reasonably limit coverage to the most necessary services.

XIX does not require payment for non-therapeutic abortions. This standing alone, is very persuasive in favor of the view advanced by petitioners. *Rosado v. Wyman,* 397 U.S. 406 (1969), *Youakim v. Miller,* U.S. , 96 S.Ct. 1399, 1402 (1976); *Northern Cheyenne Tribe v. Hallowbrest,* U.S. , 96 S.Ct. 1795, 1799 (1976). Third, Congress has recently on two occasions specifically disapproved of federal funding for abortions performed or obtained in connection with other federal programs.[37] Fourth, when Title XIX was enacted non-therapeutic abortions were illegal in most states. Finally, it is unreasonable to assume that, in an area as controversial as abortions, Congress would impose such a requirement on virtually every state by implication and without any debate whatsoever.

These are compelling reasons for rejecting the contention that Title XIX mandates state funding for non-therapeutic abortions. Nevertheless, respondents demand that non-therapeutic abortions be treated differently than all other medical services covered by Pennsylvania's medical assistance program. Respondents' view would require the state to allocate its limited medical assistance resources with a blind eye—for example to use funds for a medically unnecessary abortion while more desperate medical needs of the poor are neglected. This was not the intent of Congress. Accordingly, the decision of the lower court should be reversed.

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[37] See n. 29, supra, as well as its accompanying text.

CONCLUSION

On the basis of the foregoing arguments and authorities the petitioners seek reversal of the decision of the lower court.

Respectfully submitted,

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SUPPLEMENTAL APPENDIX

STATUTES INVOLVED

SUBCHAPTER XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

§1396. Authorization of appropriations

For the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care, there is hereby authorized to be appropriated for each fiscal year a sum sufficient to carry out the purposes of this subchapter. The sums made available under this section shall be used for making payments to States which have submitted, and had approved by the Secretary of Health, Education, and Welfare, State plans for medical assistance. Aug. 14, 1935, c. 531, Title XIX, §1901, as added July 30, 1965, Pub. L. 89-97, Title I, §121(a), 79 Stat. 343, and amended Dec. 31, 1973, Pub. L. 93-233, §13(a)(1), 87 Stat. 960.

§1396a. State plans for medical assistance—Contents

(a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

(2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchaper; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;

(3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;

(4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are

found by the Secretary to be necessary for the proper and efficient operation of the plan, and (B) for the training and effective use of paid subprofessional staff with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting any advisory committees established by the State agency;

(5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;

(6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to

time find necessary to assure the correctness and verification of such reports;

(7) provide safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with the administration of the plan;

(8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide—

(A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services, and

(B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions;

(10) provide—

(A) for making medical assistance available to all individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental secu-

rity income benefits are being paid under subchapter XVI of this chapter;

(B) that the medical assistance made available to any individual described in clause (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in clause A; and

(C) if medical assistance is included for any group of individuals who are not described in clause (A) and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, as determined in accordance with standards prescribed by the Secretary—

(i) for making medical assistance available to all individuals who would, except for income and resources, be eligible for aid or assistance under any such State plan or to have paid with respect to them supplemental security income benefits under subchapter XVI of this chapter, and who have insufficient (as determined in accordance with comparable standards) income and resources to meet the costs of necessary medical and remedial care and services, and

(ii) that the medical assistance made available to all individuals not described in clause (A) shall be equal in amount, duration, and scope;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d (a) of this title to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, and (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A);

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, and (B) effective July 1, 1969, provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiving payments for part or all of the cost of plans or projects under subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such plan or project under subchapter V of this chapter and which are included in the State plan approved under this section and (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to him under section 1396b of this title;

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide—

(A) (i) for the inclusion of some institutional and some noninstitutional care and services, and

(ii) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services, and

(B) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, for the inclusion of at least the care and services listed in clauses (1) through (5) of section 1396d(a) of this title, and

(C) in the case of individuals not included under subparagraph (B) for the inclusion of at least—

(i) the care and services listed in clauses (1) through (5) of section 1396d(a) of this title or

(ii) (I) the care and services listed in any 7 of the clauses numbered (1) through (16) of such section and (II) in the event the care and services provided under the State plan include hospital or skilled nursing facility services, physicians' services to an individual in a hospital or skilled nursing facity during any period he is receiving hospital services from such hospital or skilled nursing facility services from such facility, and

(D) for payment of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1320a-1 of this title, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as

determined under such methods and standards shall not exceed the amount which would be determined under section 1395x(v) of this title as the reasonable cost of such services for purposes of subchapter XVIII of this chapter; and

(E) effective July 1, 1976, for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis, as determined in accordance with methods and standards which shall be developed by the State on the basis of cost-finding methods approved and verified by the Secretary;

(14) effective January 1, 1973, provide that—

(A) in the case of individuals receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or who meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10) (A)—

(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar

charge with respect to the care and services listed in clauses (1) through (5) and (7) of section 1396d (a) of this title, will be imposed under the plan, and

(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10) (A)) who are not receiving aid or assistance under any such State plan and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under subchapter XVI of this chapter, as the case may be—

(i) there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, and

(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal;

(15) in the case of eligible individuals 65 years of age or older who are covered by either or both of the insurance programs established by subchapter XVIII of this chapter, provide where, under the plan, all of any deductible, cost sharing, or similar charge imposed with respect to such individual under the insurance program established by such subchapter is not met, the portion thereof which is met shall be determined on a basis reasonably related (as determined in accordance with standards approved by the Secretary and included in the plan) to such individual's income or his income and resources;

(16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom;

(17) include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security income benefits under subchapter XVI of this chapter as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums or otherwise) incurred for medical care or for any other type of remedial care recognized under State law;

(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such

individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program)) of any medical assistance correctly paid on behalf of such individual under the plan;

(19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients;

(20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases—

(A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and

facilities, for furnishing information, and for making reports;

(B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodical determination of his need for continued treatment in the institution;

(C) provide for the development of alternate plans of care, making maximum utilization of available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii), section 803(a)(1)(A)(i) and (ii) of this title or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out; and

(D) provide methods of determining the reasonable cost of institutional care for such patients;

(21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward de-

veloping and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;

(22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;

(23) except in the case of Puerto Rico, the Virgin Islands, and Guam, provide that any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and a State plan shall not be deemed to be out of compliance with the requirements of this paragraph or paragraph (1) or (10) solely by reason of the fact that

the State (or any political subdivision thereof) has entered into a contract with an organization which has agreed to provide care and services in addition to those offered under the State plan to individuals eligible for medical assistance who reside in the geographic area served by such organization and who elect to obtain such care and services from such organization; [as amended July 1, 1975, Pub. L. 94-48, 89 Stat. 247]

(24) effective July 1, 1969, provide for consultative services by health agencies and other appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties to pay for care and services (available under the plan) arising out of injury, disease, or disability, (B) that where the State or local agency knows that a third party has such a legal liability such agency will treat such legal liability as a resource of the individual on whose behalf the care and services are made available for purposes of paragraph (17) (B), and (C) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual, the State or

local agency will seek reimbursement for such assistance to the extent of such legal liability;

(26) effective July 1, 1969, provide (A) for a regular program of medical review (including medical evaluation) of each patient's need for skilled nursing facility care or (in the case of individuals who are eligible therefor under the State plan) need for care in a mental hospital, a written plan of care, and, where applicable, a plan of rehabilitation prior to admission to a skilled nursing facility; (B) for periodic inspections to be made in all skilled nursing facilities and mental institutions (if the State plan includes care in such institutions) within the State by one or more medical review teams (composed of physicians and other appropriate health and social service personnel) of (i) the care being provided in such nursing facilities (and mental institutions, if care therein is provided under the State plan) to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular nursing facilities (or institutions) to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities (or institutions), (iii) the necessity and desirability of the continued placement of such patients in such nursing facilities (or institutions), and (iv) the feasibility of meeting their health care needs through alternative institutional or noninstitutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections together with any recommendations to the State agency administering or supervising the administration of the State plan;

(27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency may from time to time request;

(28) provide that any skilled nursing facility receiving payments under such plan must satisfy all of the requirements contained in section 1395x(j) of this title, except that the exclusion contained therein with respect to institutions which are primarily for the care and treatment of mental diseases and tuberculosis shall not apply for purposes of this subchapter; [as amended, Oct. 30, 1972, Pub. L. 92-603, 86 Stat. 1424]

(29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

(30) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b (i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments (including payments for any drugs provided under the plan) are not in excess of reasonable charges consistent with efficiency, economy, and quality of care;

(31) provide (A) for a regular program of independent professional review (including medical evaluation of each patient's need for intermediate care) and a written plan of service prior to admission or authorization of benefits in an intermediate care facility as determined under regulations of the Secretary; (B) for periodic on-site inspections to be made in all such intermediate care facilities (if the State plan includes care in such institutions) within the State by one or more independent professional review teams (composed of physicians or registered nurses and other appropriate health and social service personnel) of (i) the care being provided in such intermediate care facilities to persons receiving assistance under the State plan, (ii) with respect to each of the patients receiving such care, the adequacy of the services available in particular intermediate care facilities to meet the current health needs and promote the maximum physical well-being of patients receiving care in such facilities, (iii) the necessity and desirability of the continued placement of such patients in such facilities, and (iv) the feasibility of meeting their health care needs through alternative institutional or non-institutional services; and (C) for the making by such team or teams of full and complete reports of the findings resulting from such inspections, together with any recommendations to the State agency administering or supervising the administration of the State plan;

(32) provide that no payment under the plan for any care or service provided to an individual by a physician, dentist, or other individual practitioner shall be made to anyone other than such individual or such physician, dentist, or practitioner, except that payment may be made (A) to the employer of such physician, dentist,

or practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (B) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service;

(33) provide—

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations precsribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the penultimate sentence of this subsection; and

(B) that the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa (a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this title the function of determining whether institutions and

agencies meet the requirements for participation in the program under such plan;

(34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;

(35) effective January 1, 1973, provide that any intermediate care facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such intermediate care facility or any of the property or assets of such intermediate care facility receiving payments under such plan must supply to the licensing agency of the State full and complete information as to the identity (A) of each person having (directly or indirectly) an ownership interest of 10 per centum or more in such intermediate care facility, (B) in case an intermediate care facility is organized as a corporation, of each officer and director of the corporation, and (C) in case an intermediate care facility is organized as a partnership, of each partner; and promptly report any changes which would affect the current accuracy of the information so required to be supplied; and

(36) provide that within 90 days following the completion of each survey of any health care facility,

laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this title, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization.

Notwithstanding paragraph (5), if on January 1, 1965, and on the date on which a State submits its plan for approval under this subchapter, the State agency which administered or supervised the administration of the plan of such State approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) was different from the State agency which administered or supervised the administration of the State plan approved under subchapter I of this chapter (or subchapter XVI of this chapter, insofar as it relates to the aged), the State agency which administered or supervised the administration of such plan approved under subchapter X of this chapter (or subchapter XVI of this chapter, insofar as it relates to the blind) may be designated to administer or supervise the administration of the portion of the State plan for medical assistance which relates to blind individuals and a different State agency may be established or designated to administer or supervise the administration of the rest of the State plan for medical assistance; and in such case the part of the plan which each such agency

administers, or the administration of which each such agency supervises, shall be regarded as a separate plan for purposes of this subchapter (except for purposes of paragraph (10)). For purposes of paragraphs (9) (A), (29), (31), and (33), and of section 1396b(i) (4) of this title, the terms "skilled nursing facility" and "nursing facility" do not include a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts.

For purposes of paragraph (10) any individual who, for the month of August 1972, was eligible for or receiving aid or assistance under a State plan approved under subchapter I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter and who for such month was entitled to monthly insurance benefits under subchapter II of this chapter shall for purposes of this subchapter only be deemed to be eligible for financial aid or assistance for any month thereafter if such individual would have been eligible for financial aid or assistance for such month had the increase in monthly insurance benefits under subchapter II of this chapter resulting from enactment of Public Law 92-336 not been applicable to such individual. [as amended, July 1, 1975, Pub. L. 94-48, 89 Stat. 247]

Approval by Secretary

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years;

or

(2) effective July 1, 1967, any age requirement which excludes any individual who has not attained the age of 21 and is or would, except for the provisions of section 606(a) (2) of this title, be a dependent child under part A of subchapter IV of this chapter; or

(3) any residence requirement which excludes any individual who resides in the State; or

(4) any citizenship requirement which excludes any citizen of the United States.

Same; reduction of aid or assistance under State plans under other subchapters

(c) Notwithstanding subsection (b) of this section, the Secretary shall not approve any State plan for medical assistance if he determines that the approval and operation of the plan will result in a reduction in aid or assistance in the form of money payments (other than so much, if any, of the aid or assistance in such form as was, immediately prior to the effective date of the State plan under this subchapter, attributable to medical needs) provided for eligible individuals under a plan of such State approved under subchapters I, X, XIV, or XVI of this chapter, or part A of subchapter IV of this chapter.

(d) Repealed. Pub.L. 92-603, Title II, §231, Oct. 30, 1972, 86 Stat. 1410.

Continued eligibility of families determined ineligible because of income and resources or hours of work limitations of plan

(e) Notwithstanding any other provision of this subchapter, effective January 1, 1974, each State plan approved under this subchapter must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of subchapter IV of this chapter in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this subchapter (as though the family was receiving aid under the plan approved under part A of subchapter IV of this chapter) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of subchapter IV of this chapter because of income and resources or hours of work limitations contained in such plan.

Effective date of State plan as determinative of duty of State to provide medical assistance to aged, blind, or disabled individuals

(f) Notwithstanding any other provision of this subchapter, except as provided in subsection (e) of this section, no State not eligible to participate in the State plan program established under subchapter XVI of this chapter shall be required to provide medical assistance to any aged, blind, or disabled individual (within the meaning of subchapter XVI of this chapter) for any month unless such State would be (or would have been) required to provide medical assistance to such individual for such month had its plan for medical assistance approved under this subchapter and in effect on January 1, 1972, been in effect in such month, except that for this purpose any such individual shall be deemed eligible for medical assistance under such State plan if (in addition to meeting such other requirements as are or may be imposed under the State plan) the income of any such individual as determined in accordance with section 1396b(f) of this title (after deducting any supplemental security income payment and State supplementary payment made with respect to such individual, and incurred expenses for medical care as recognized under State law) is not in excess of the standard for medical assistance established under the State plan as in effect on January 1, 1972. In States which provide medical assistance to individuals pursuant to clause (10) (C) of subsection (a) of this section, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10) (A) of that subsection if that individual is, or is eligible to be (1) an individual with respect to whom there is payable a State supplementary payment on the basis of which similarly situated individuals are eligible to receive medical assistance equal in amount, duration, and scope to that provided to individuals eligible under clause (10) (A), or (2) an eligible individual or eligible spouse, as defined in subchapter XVI of this chapter, with respect to whom supplemental security income benefits are payable; otherwise that individual shall be considered to be an individual eligible for medical assistance under clause (10) (C) of that subsection. In States which do not provide medical assistance to individuals pursuant to clause (10) (C) of that subsec-

tion, an individual who is eligible for medical assistance by reason of the requirements of this section concerning the deduction of incurred medical expenses from income shall be considered an individual eligible for medical assistance under clause (10) (A) of that subsection.

Aug. 14, 1935, c. 531, Title XIX, §1902, as added July 30, 1965, Pub.L. 89-97, Title I, §121(a), 79 Stat. 344, and amended Jan. 2, 1968, Pub.L. 90-248, Title II, §§210(a) (6), 223(a), 224(a), (c) (1), 227(a), 228(a), 229(a), 231, 234(a), 235(a), 236(a), 237, 238, 241(f) (1)-(4), Title III, §302(b), 81 Stat. 896, 901-906, 908, 911, 917, 929; Aug. 9, 1969, Pub.L. 91-56, §2(c), (d), 83 Stat. 99; Dec. 28, 1971, Pub.L. 92-223, §4(b), 85 Stat. 809; Oct. 30, 1972, Pub.L. 92-603, Title II, §§208(a), 209(a), (b) (1), 221(c) (5), 231, 232(a), 236(b), 237(a) (2), 239(a), (b), 240, 246(a), 249(a), 255(a), 268(a), 274(a), 278(a) (18), (19), (b) (14), 298, 299A, 299D(b), 86 Stat. 1381, 1389, 1410, 1415-1418, 1424, 1426, 1446, 1450, 1452, 1453, 1460, 1462; Dec. 31, 1973, Pub.L. 93-233, §§13(a) (2)-(10), 18(*o*)-(q), (x) (1)-(4), 87 Stat. 960-963, 971, 972; Aug. 7, 1974, Pub.L. 93-368, §9(a), 88 Stat. 422.

Consent to suit and waiver of immunity by State

(g) Notwithstanding any other provision of this subchapter, a State plan for medical assistance must include a consent by the State to the exercise of the judicial power of the United States in any suit brought against the State or a State officer by or on behalf of any provider of services (as defined in section 1395x(u) of this title) with respect to the application of subsection (a) (13) (D) of this section to services furnished under such plan after

June 30, 1975, and a waiver by the State of any immunity from such a suit conferred by the 11th Amendment to the Constitution or otherwise. [As amended Dec. 31, 1975, Pub.L. 94-182, Title I, §111(a), 89 Stat. 1054.]

[Note: 42 U.S.C. §1396(b) through §1396(i) omitted.]

REGULATION INVOLVED

9100 MEDICAL ASSISTANCE (MA)—GENERAL

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(This Section provides a general description of the medical care programs for both the categorically and medically needy persons on whose behalf the Department makes payments to medical agencies or practitioners. The regulations as given in this Section provide only a general overview of the medical care programs. They do not here include all the details of the regulations that govern the medical care programs. The details are set forth in other Sections of this Manual.)

PART I—ADMINISTRATION OF MEDICAL CARE PROGRAMS

The Department of Public Welfare (Office of Medical Programs) has responsibility for establishing the scope, standards, regulations, procedures and fees for medical care provided for (1) categorically needy persons who are eligible for the full medical program, i.e. for persons financially eligible who do or do not receive money payments depending on whether or not they meet all other points of eligibility, and (2) for the medically needy persons who receive limited medical assistance because their incomes are insufficient to pay for major medical expenses although sufficient for their everyday necessities.

The County Assistance Office has responsibility for administering the medical care programs on the local level within Departmental regulations, and subject to review and supervision by the State Office of Medical Programs.

Additional information is given in Part IV on the responsibilities and functions of the State Office of Medical

Programs and the County Assistance Office in administration of the medical care programs, as well as others involved, such as the Medical Assistance Advisory Council. and the County Medical and Dental Consultants.

PART II—MEDICAL CARE PROGRAMS FOR CATEGORICALLY NEEDY PERSONS AND FOR SCHOOL CHILDREN WHO ARE ONLY MEDICALLY NEEDY

GENERAL POLICIES

A. PURPOSE OF PROGRAM

1. *For Categorically Needy Persons*

The broad general purpose of the Department's Office of Medical Programs, as set forth in the Public Assistance Law, is to provide assistance to the needy and distressed, to enable them to maintain for themselves and their dependents a decent and healthful standard of living, and to do this in such a way as to promote self-respect, rehabilitation and, if possible, self-dependency.

Included in the needy and distressed are (1) those persons who have applied for and have been found eligible for a money payment from the Office of Public Assistance, and (2) those persons who have been found financially eligible but are not eligible for a money payment because they do not meet State regulations. However, under Title XIX of the Social Security Law these persons are eligibl for the same vendor payments for the medical care that is provided persons actually receiving a money payment.

Also specified in the Law, among the responsibilities of the County Assistance Office are these: "To take measures to promote the welfare and self-dependency of indi-

viduals and families eligible for assistance by helping them to secure rehabilitative, remedial or other constructive aid through local community resources, or in the absence or inadequacy of such resources, through direct provision of such aid. . ." Such aid has heretofore been provided only to persons receiving money payments. Title XIX, the 1965 amendments to the Social Security laws, broadens this responsibility to provide the same service to people financially eligible but who do not meet one or more of Pennsylvania's requirements for money payment assistance. (See 3910)

In dealing with the problem of dependency the Department has the dual purpose of relieving the distress and suffering of individuals and families unable to be completely self-dependent, and at the same time promoting self-dependence by helping each individual and family applying for public assistance to deal more effectively with the environmental and personal causes of their dependency.

The importance of medical care in carrying out this dual purpose is clear. Adequate medical care to relieve distress and suffering or to promote positive health, or both, with the goal of enabling the individual and family to use their maximum potential for self-dependence must now be available to all categorically needy persons.

2. *For School Children*

The purpose of the program is to meet the cost of treatment a child needs for a condition recorded in the child's school health record, and for which the child's parents or guardian are unable (according to law and regulations) to pay.

B. METHOD OF PAYMENT

In accordance with public assistance regulations and fee schedules, the Department makes direct payments to practitioners and vendors for services, medications, and medical supplies provided. This system is necessary because medical needs are extremely varied and unpredictable, requiring an individualized and flexible way of meeting these needs. The practitioner and vendor send bills to the appropriate fiscal agent or the Comptroller's Office of the B.P.W.

Payment for such health items as the usual household medicine chest supplies and items of personal care is not included in the system of practitioner and vendor payments because these items constitute a common, predictable, continuing need. Therefore, an amount of money to meet this need is included in the money payment to the recipient, in the determination of eligibility of the need amount of the non-money payment recipient, and in the evaluation of resources of a medically needy school child.

C. ELIGIBILITY FOR CARE

A resident of Pennsylvania, either in the state or temporarily outside is eligible for medical care if he is a categorically needy person irrespective of whether he is or is not receiving money payments. A newborn infant for whom an application has not as yet been made is also eligible.

A school child is eligible for medical care: (1) if he is categorically needy, *or* (2) if he has been certified as medically needy, *and* (3) the referral to public assistance has been made by the School Nurse. (A "school child" includes a child attending, or scheduled to enter within the

current year, a Pennsylvania (public or private) elementary, grade or high school, or kindergarten that is an integral part of a local school district.) A summary of the services and eligibility conditions for Medical Assistance for school children is given in Leaflet No. 5 available from the County Board of Assistance, or from the Department of Public Welfare, Harrisburg.

Since medical care is paid only for eligible persons, it is the responsibility of the practitioner or vendor, in order to be assured of payment, to verify with the County Board of Assistance that the person is eligible.

D. PROFESSIONAL PARTICIPATION

The Public Assistance medical care program, operating on a voluntary participation basis, is open to any practitioner of medicine, osteopathy, chiropractic, or dentistry, any clinic, pharmacist, nursing home, hospital, clinic, or vendor of medical supplies in Pennsylvania or in another State who meets the requirements described under the regulations for each of the participating professions. The practitioner or vendor who participates in the program, giving services, thereby signifies his agreement to comply with the regulations and intent of the program.

Subject only to the practitioner's, vendor's, or institution's willingness to participate in the program and abide by the regulations, the patient has the right of free choice of practitioner, vendor, or institution.

E. SERVICES PAID FOR

1. *Summary*

The Department of Public Welfare pays for those types of medical and allied services given in the home, office, clinic, or hospital, that are generally recognized as necessary treatment of illnesses.

It is the Department's intention to pay for adequate medical care, in accordance with accepted standards of good medical practice, to achieve the purposes set forth earlier.

There is no intention to pay for extravagant or superfluous medical care, or care that would be beyond the means of the average family of moderate income. Nor will the Department pay for new and expensive medication or treatment that is still in the experimental stage.

The Department expects that the professional participants, in giving services and prescribing supplies within the scope of the program, will not exceed in any individual instance what is essential for adequate medical care for that individual.

The fees paid by the Department are in full payment of services given. A practitioner who seeks or accepts additional remuneration of any kind from the patient, or any other person, shall be considered as violating the regulations of the medical care program and will be subject to disciplinary action.

The program of medical care includes: physicians', clinic, and dental services, medications, medical goods and supplies, ambulance service, inpatient hospital care, hospital-home care, nursing care in the home, public nursing home care, private nursing home care, care in a mental institution, and medical-social services, in accordance with the regulations and fees established by the Department.

The program of medical care is supplemental to other existing resources for medical services or supplies, and pre-

supposes full use of other tax-supported or voluntary agencies or facilities for meeting medical needs.

It is the responsibility of each County Assistance Office to be aware of all such resources in the area and to see that these are fully used in meeting the medical needs of assistance recipients and others who apply for medical assistance.

The Department should be charged only for services that are not available through any other existing tax-supported or voluntary facility. It is recognized that the services of many such facilities are limited in scope and availability. However, some are available throughout the State. The Department will not pay for or duplicate services that are available from these state-wide facilities and agencies. They include: treatment for rabies—available through County Authorities; vaccinations—available through local school districts or facilities of the State Department of Health or local boards of health; physicians' services to assistance recipients in hospitals; medical care for recipients certified for medical services under the Workmen's Compensation Act or the Occupational Disease Act; services for handicapped children—provided by the State Department of Health; treatment for tuberculosis or venereal diseases—the responsibility of State Health Clinics. Since the diagnosis of tuberculosis and venereal disease may not be known to the patient when he first seeks medical care, the Department will pay for the initial visit to a private physician or a hospital clinic when necessary to establish a diagnosis. (This is not paid for a school child who is only medically needy, since diagnostic service is provided in the course of the school health examination.)

The program of medical care as defined in regulations is designed to provide treatment for all the usual medical needs arising from illness, disability, or infirmity, and for certain needs associated with restoration to self-support. Specific situations may arise in which adequate medical care requires unusual or exceptional types of treatment, medication, or supplies that are not specified in the public assistance regulations and are not available from any other source. In such cases, at the request of the practitioner, transmitted through the County Assistance Office, the State Office of Public Assistance will review the circumstances and approve and pre-authorize the service when it is deemed necessary to meet adequately the needs of the eligible patient.

2. *Physicians' Services*

In accordance with the specific regulations governing physicians' services, the Department pays for office and home calls for chronic or acute illness. Home calls are paid for only when it is situationally impossible or medically inadvisable for the patient to go to the physician's office.

In cases of acute illness the Department will pay for the minimum number of calls deemed necessary by the physician for adequate medical care in each individual instance.

In chronic illness, payment is limited to a maximum of three calls per month. It is not expected, however, that this maximum will be charged in instances where one or two calls would have sufficed.

Obstetrical care and minor surgery, performed in the home or office, are paid for.

X-ray study in the physician's office, if necessary for diagnosis, is also a covered service. The Department does not pay for diagnostic laboratory tests and x-rays provided in the course of the school health examination.

The services of a physician for a complete physical examination may be paid if needed to determine a recipient's condition or an applicant's eligibility for assistance; for the annual general medical examination of public assistance recipients in private nursing homes; and for other needed special medical examinations. Prior authorization is required.

On written prescription by the physician, payment is made for drugs. Payment for drugs on one prescription is limited to a 45 days' supply. If the charge for the medication is more than $15 prior authorization through the County Assistance Office is required.

Medication dispensed by a physician during a home or office call may be paid for if the medication costs the physician $2 or more; but prior authorization is required if the charge is more than $15.

In addition to the physicians' services summarized above, the Departmeent also pays the following for an eligible school child: eye examinations and refractions, eyeglasses, and podiatrist's services.

For a patient who is receiving skilled nursing or intermediate care, the Department does not pay for medical services given by a physician who owns that institution in whole or in part, has a financial interest in it, operates it, or is acting in any other capacity that indicates he is not an independent contractor.

The detailed regulations on physicians' services are in medical assistance regulations 9411.

3. *Pharmaceutical Services*

In accordance with the specific regulations governing pharmaceutical services, the Department pays for drugs, medical supplies and equipment for eligible persons.

If the charge for any item is more than $15 for one prescription, the Department pays the pharmacist only if he has written authorization from the County Assistance Office before filling the prescription.

Payment for any prescription is limited to a 45 days' supply.

For a person in a nursing home for whom the Department is making a nursing home care payment, payment will not be made for any services, medications, and supplies included in the medical assistance definition of skilled nursing or intermediate care.

The detailed regulations on pharmaceutical and other vendor services are in medical assistance regulations 9413.

4. *Clinic Services*

Payment is made for: pre-natal care, and treatment for chronic and acute illness, with limits on the number of chargeable visits, as outlined above under physicians' services; and x-ray studies for diagnosis or definition, with the exception outlined above under physicians' services. For the eligible school child, payment may be made for eye examinations and refractions.

Clinic pharmacies are expected to fill prescriptions written by clinic physicians. Payment will not be made for

drugs and supplies that are ordinarily dispensed without charge to non-assistance patients who are unable to pay.

The detail regulations on clinic services are in medical assistance regulations 9412.

5. *Dental Services*

In line with the Department's intent to provide adequate, but not extravagant or superfluous care, priorities for dental treatment have been established as a basis for restrictions on services. The priorities are listed in medical assistance regulations in 9414.

Payment is made for dental x-rays and medications prescribed by dentists, in addition to other dental care.

6. *Ambulance Services*

Payment may be made for necessary ambulance services if they are not available without charge to other needy persons in the community. The limitations are set forth in medical assistance regulations 9415.

7. *Nursing Care in the Home*

Payment is made for the nurse's initial visit on the request of the patient or any interested person. Subsequent visits will be paid for only if made on the written order of the attending physician.

The Department will pay for nursing service for chronic or acute illness, maternity service, or instruction of the patient, in accordance with the medical assistance regulations and the fee schedule.

8. *Inpatient Hospital Care*

Payment is made for inpatient hospital care, based upon documented medical necessity. For specifics, see medical assistance regulations 9421.

9. *Hospital-Home Care*

Payment is made for hospital-type care in the home provided by the hospital as an uninterrupted continuation of inpatient hospital care. Payment is for up to 180 days in a benefit period. For specifics, see medical assistance regulations 9422.

10. *Skilled Nursing Care*

Payment is made for skilled nursing care for all eligible persons.

Payment may continue for as long as the need and eligibility continue. For specifics, see medical assistance regulations 9424.

11. *Intermediate Care*

Payment is made for intermediate care for all eligible persons.

Payment may continue for as long as need and eligibility continue. For specifics, see medical assistance regulations 9425.

12. *Care in a Mental Institution*

Payment is made for service in an institution for mental diseases for a person aged 65 or older and under age 21 who needs psychiatric service. Payment may continue for as long as the need and eligibility continue. For specifics, see medical assistance regulations 9426.

13. *Medical-Social Services*

A broad range of social services, including specific services related to illness, is provided as needed to persons applying for or receiving public assistance money payments. The objective is to enable them to attain or retain independence or self-care or both.

Specific social services related to illness are provided as needed in relation to a school child for whom an application is being made for Medical Assistance, or who is receiving Medical Assistance. This includes social services in medical emergencies.

F. COOPERATION BETWEEN PRACTITIONER AND PUBLIC ASSISTANCE STAFF

Cooperation between the practitioner and the public assistance staff is necessary for effective planning with the patient and his family. To restore the patient to health as early and completely as possible, he and his family will often need social services provided by the public assistance staff to help the patient and family in carrying out the plan of treatment advised by the practitioner.

The public assistance staff will give the practitioner any information it has on social factors that may have a positive or negative bearing on treatment. Such information may be on environmental factors, the individual's capacity to understand and participate in a medical treatment plan, his responsibilities, his material and personal resources, and his ability to use resources effectively.

It is recognized that, under a program that allows the patient the right to initiate medical services, a certain number of requests for unnecessary care may result. Practitioners, particularly physicians, are requested to report to the County Assistance Office the names of Medical Assistance recipients who continue to make unnecessary demands for medical attention. The County Assistance Office will cooperate with the practitioner in trying to solve such problems.

The County Assistance Office will bring to the attention of the practitioners involved the names of recipients who "shop" for medical care, and are treated by more than one practitioner during the same month. If the practitioners concerned are unable to control the situation, the County Assistance Office will ask the recipient to choose one practitioner and will notify the practitioners that only that one will be paid, except in an emergency when the practitioner selected by the recipient is not available to treat him.

PART III—MEDICAL CARE PROGRAM FOR PERSONS WHO ARE ONLY MEDICALLY NEEDY

The Department pays for the medical services listed below (in items 1 through 10) for eligible persons who are taking care of their everyday living expenses themselves, but have insufficient income, according to law and regulations, to pay for these major medical expenses:

1. *Inpatient Hospital Care* (same as for assistance recipient—see Part II E item 8).

2. *Hospital-Home Care* (same as for assistance recipient—see Part II E. item 9).

3. *Nursing Care in the Home* (same as for assistance recipient—see Part II E. item 7).

4. *Skilled Nursing Care*
5. *Intermediate Care*
6. *Care in a Mental Institution*
7. *Medical-Social Services*
8. *Physician's Services*
9. *Clinic Services*
10. *Transportation*

Specific social services related to illness are provided as needed to persons applying for or receiving Medical Assistance. This includes social services in medical emergencies.

PART IV—ORGANIZATION

A. STATE OFFICE OF MEDICAL PROGRAMS OF THE DEPARTMENT OF PUBLIC WELFARE

In the administration of the Medical Programs, the responsibilities of the State Office are:

a. To establish standards, regulations, and fees governing medical care of a quality acceptable to competent authorities in their respective medical fields.

b. To obtain maximum cooperation from practitioners in providing quality services for assistance recipients and other medically needy persons, as economically as possible with due regard for essential needs of the patients and a fair return to the practitioner.

c. To make maximum use of all existing medical and allied resources available to medically needy persons.

d. To promote coordination of the Medical Programs with other State-wide health programs.

e. To secure the advice of the health professions through the Medical Assistance Advisory Council, and encourage each County Assistance Office to establish a County Medical Care Committee.

The State Office of Medical Programs, undertaking to provide medical care for eligible persons through a system of direct payments to practitioners and vendors, is in effect a non-medical agency purchasing the services of individual members of medical and allied professions throughout the State.

In administering the Medical Care program, circumstances occasionally arise indicating that certain practitioners may not be observing the regulations of the Department on giving services or invoicing for services, or may possibly be providing inferior, inadequate, or incorrect medical care. Under such circumstances, an investigation will be initiated and, if the facts warrant, consideration will be given to disciplinary action against the practitioner.

B. MEDICAL ASSISTANCE ADVISORY COUNCIL

1. *Membership*

The members of the Medical Assistance Advisory Council are appointed by the Secretary of Public Welfare for a two or three year term. The appropriate State professional organizations are requested to make recommendations for appointment to the Council.

The Council consists of two representatives, respectively, from the fields of medicine, osteopathy, dentistry,

nursing, nursing home care, pharmacy, and hospital care; one representative each from the schools of public health, and medical schools; the Deputy Secretary of the Pennsylvania Department of Health; the Commissioner of General and Special Hospitals, and the Commissioner of Medical Programs. The Director of Medical Assistance is Chairman of the Council.

The members of the Council serve without pay but are reimbursed, in accordance with Departmental regulations, for necessary expenses incurred in their service as Council members.

2. *Functions*

The functions of the Council are:

a. To give professional advice to the Office of Medical Programs on the development of sound policies and standards of medical assistance.

b. To encourage the participation of well-qualified practitioners in the medical programs.

c. To interpret the programs to the professional organizations and to individual members of the professions.

d. To recommend measures designed to improve the quality of health care provided for the needy.

e. To promote professional support of the programs in relation to needed legislation and appropriations.

C. COUNTY ASSISTANCE OFFICE

The general responsibility of the County Assistance Office in relation to the Medical Care Programs is to administer them in accordance with the policies and regulations of the Department of Public Welfare.

In administering the Medical Programs, the County Assistance Office consults, as appropriate, with its related professional staff and advisory groups.

Almost every County Assistance Office has on the staff a County Medical Consultant and a County Dental Consultant (for their functions, see D below).

The County Assistance Office makes the fullest possible use of the consultants for liaison between the county administration and the professional organizations; for advice on matters of dispute or disciplinary action between the agency and members of the professions in administering medical aspects of the programs; for advice on medical policy, professional standards, and fees for service; and in the review of invoices submitted and services rendered, in any way necessary to assure the agency of value received in the services it purchases.

The County Assistance Office or consultants may also seek the advice of other individuals or representatives of allied professions, or of organizations of recognized standing in the fields of health and social welfare whose advice may assist in promoting the objectives of the Medical Programs.

The County Assistance Office maintains a current list of all professional persons and agencies in the county who

participate in the Medical Care Programs. This list is maintained to facilitate transmission of official notices and to provide a list from which an eligible person may, if he wishes, select a practitioner.

D. COUNTY MEDICAL AND DENTAL CONSULTANTS

The County Assistance Office shall have on its staff a Medical and a Dental Consultant.

The primary function of the Consultant is to provide professional advice on individual cases as needed. He works directly with staff on services to individual clients, on specific medical or dental problems, etc. The Consultant also has functions in staff development and in liaison with medical, dental, and allied professions.

The Consultant acts in an advisory or consultative capacity to the county assistance administration; he does not administer the public assistance medical or dental programs. The county assistance administration retains authority for accepting or rejecting the Consultant's recommendations, for the agency is legally responsible for final administrative decisions.

The Consultants are under the general administrative direction of the County Assistance Office. The Medical Consultant is under the professional direction of the Medical Director of the Office of Medical Programs. The Dental Consultant is under the professional direction of the State Office Bureau of Medical Services which has a Dental Consultant.

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
Harrisburg, September 25, 1975

MEDICAL ASSISTANCE MEMORANDUM
NO. 57

Supplement No. 2

SUBJECT: REIMBURSEMENT FOR NONTHERAPEUTIC ABORTIONS—TEMPORARY REVISED POLICY

TO: PHYSICIANS
HOSPITALS
FAMILY PLANNING CLINICS
FREE-STANDING CLINICS
INDEPENDENT LABORATORIES
REGIONAL OFFICES
COUNTY ASSISTANCE OFFICES

FROM: JAMES R. HARRIS, M.D.
ACTING DEPUTY SECRETARY FOR MENTAL HEALTH AND MEDICAL SERVICES

Previous Therapeutic Abortion Policy

Since the beginning of the Medical Assistance Program and until July 20, 1975, therapeutic abortions were covered under the following circumstances: (1) There is

documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother; (2) There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency; or (3) There is documented medical evidence that a continuance of a pregnancy resulting from legally established statutory or forcible rape or incest, may constitute a threat, to the mental or physical health of a patient; (4) Two other physicians chosen because of their recognized professional competency have examined the patient and have concurred in writing; and (5) The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals.

Social and economic reasons were never considered as justification for a therapeutic abortion.

Temporary Revised Policy

In accordance with recent Federal court rulings and until further notice, the Medical Assistance Program under a temporary revised policy will cover services and payments for nontherapeutic abortions, as well as therapeutic abortions, provided to eligible recipients by licensed physicians in licensed facilities or a physician's office. This temporary revised policy is effective for such services on and after July 21, 1975.

When and Where Abortions May Be Performed

During the first twelve (12) weeks of a pregnancy, a therapeutic or nontherapeutic abortion may be performed in a licensed physician's office, a clinic approved by the Department of Health or a licensed hospital facility.

After the first twelve (12) weeks of a pregnancy and until the end of the second trimester, a therapeutic or nontherapeutic abortion may be performed only in a licensed hospital.

Only a therapeutic abortion may be performed in the third trimester in a licensed hospital.

Abortions Performed in a Physician's Office

Under the temporary revised abortion policy, licensed physicians will be reimbursed for therapeutic or nontherapeutic abortions performed in their offices according to the procedure codes and fees in Specimen A.

Physicians will bill on a Standard Medical Invoice, Form PA 259. An Invoice Transmittal, Form PA 259-S, must accompany each group of invoices submitted to the Division of Finance, 123 Walnut Street, Harrisburg, Pennsylvania 17101.

Abortions Performed in a Hospital Clinic or Other Clinic Approved by the Department of Health

Under the temporary revised policy for therapeutic or nontherapeutic abortions performed during the first twelve (12) weeks of pregnancy in a hospital outpatient clinc or other clinic approved by the Department of Health, a maximum fee of $50.00 is allowed for the use of the facility, medications, and all supplies used in the performance of the procedure. Separate laboratory and x-ray fees will be reimbursed to the actual provider in accordance with fees in Appendix I of Section 9411. A separate professional fee will be paid to an independent licensed physician or group practice performing the procedure in accordance with fees in Specimen A.

The DPW fees are maximum rates allowed. If the facility, physician, or other providers' fees to the general public are lower, then the lower fees are to be charged to the Medical Assistance Program.

Invoicing Procedures

The Standard Medical Invoice, Form PA 259 will be used by hospital clinics and clinics approved by the Department of Health when submitting claims for abortions performed during the first twelve (12) weeks of a pregnancy. Free-standing clinics approved by the Department of Health are listed in Specimen B.

The maximum fee of $50.00 and itemized laboratory and x-ray fees for services provided by the facility will be listed on the PA 259. Form PA 259-S, Invoice Transmittal, must accompany each group of invoices submitted to the Division of Finance, 123 Walnut Street, Harrisburg, Pennsylvania 17101 for payment.

Laboratory tests and x-rays performed by a hospital or independent laboratory or x-ray facility will be billed on a Standard Medical Invoice, Form PA 259, in the usual manner by such providers.

The separate professional fee will be billed on a Standard Medical Invoice, Form PA 259, and submitted along with an Invoice Transmittal, Form PA 259-S, to the Division of Finance, 123 Walnut Street, Harrisburg, Pennsylvania 17101. Hospital-based salaried physicians covering outpatient clinics are not eligible to bill a separate professional fee.

Abortions Performed on an Inpatient Basis

Under the temporary revised policy all therapeutic or nontherapeutic abortions for Medical Assistance patients after the first twelve (12) weeks and until the end of a pregnancy, or a therapeutic abortion done in the third trimester, must be performed on an inpatient basis in a licensed hospital or a short procedure unit of a hospital. An interim payment will be made to the hospital subject to an annual cost adjustment.

The admission must be post-approved under PDUR or alternative system of concurrent review. Also, the hospital must obtain a PA 5-M from the County Assistance Office certifying the benefit days available for a recipient.

Invoicing Procedures

Hospital invoices for inpatient abortions are submitted through the fiscal agent under the same procedure used for other inpatient services. The invoices will show the MA per diem charges for room and board and other related charges for the inpatient care, except the physician's fee.

The attending physician will invoice Blue Shield on a Doctor's Service Report using the procedure codes and terminology listed in Specimen A. An Invoice Transmittal, Form PA 259-S must accompany each group of invoices submitted to Pennsylvania Blue Shield, Box 19, Camp Hill, Pennsylvania 17011. Hospital-based salaried physicians covering inpatient services are not eligible to bill a physician's fee since the salary costs are in the hospital's audited costs.

Medical Assistance Memorandum No. 57

Inquiries on Temporary Revised Policy

Any questions regarding the temporary revised policy may be referred to the Bureau of Medical Assistance, Policy Division, Room 523, Health and Welfare Building, Harrisburg, Pennsylvania 17120, telephone 717/787-7362.

Pennsylvania Medical Society Position

ABORTION POLICY

Established October, 1970, by the Pennsylvania Medical Society*

The House of Delegates, the ruling body of the 12,000 physician-member Pennsylvania Medical Society, considered at its October, 1970, annual meeting several proposals for changing the State Society policy concerning abortions and then took a position which basically is a reaffirmation of a policy established in 1967.

Therefore, it is the position of the Pennsylvania Medical Society that abortions should be legal only under the following circumstances:

"1. There is documented medical evidence that continuance of the pregnancy may threaten the health or life of the mother;

"2. There is documented medical evidence that the infant may be born with incapacitating physical deformity or mental deficiency, or

"3. There is documented medical evidence that continuance of a pregnancy, resulting from legally established statutory or forcible rape or incest, may constitute a threat to the mental or physical health of a patient;

"4. Two other physicians chosen because of their recognized professional competence have examined the patient and have concurred in writing; and

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* This position was reaffirmed in 1974. *Health Care in Pennsylvania*: 1974, 77 Pennsylvania Medicine, 30, 36 (August, 1974).

"5. The procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals."

Essentially, the position specifies that there be recognized medical reasons for performing an abortion rather than social reasons.

So-called "abortion on demand" legislation makes the procedure available to all who want it for either medical or social reasons or a combination of both. For instance, such legislation would enable a woman to have an abortion performed legally just because she wants an abortion. She could be in good physical and mental health, the fetus may be presumed to be normal, the process of childbirth and rearing another baby may pose no threat to her physical and mental health and she still would be entitled to an abortion in a state where "abortion on demand" legislation exists. Under those circumstances, there may be social justification for such an abortion but no specific medical justification. "Social justification" might include abortion as a form of population control or as a means of avoiding the social stigma attached to unwed females becoming mothers, just to mention two examples.

The Pennsylvania Medical Society favors family planning and through it, population control, but it does not recognize abortion as a medically accepted method of family planning or population control. Opponents of the medical society position point out that conception prevention, medication, devices and methods are readily available and are even provided upon request through Pennsylvania's "Medicaid" program for the medically indigent. The position favors conception prevention where such prevention is desired and notes that although a modern medical abortion is a relative safe procedure it nevertheless carries some small risk to the health of the patient.

If we take the example of an unwed pregnant female, the Pennsylvania Medical Society position well may permit an abortion to be performed if the three physicians specified agree that the female's emotional reaction to the social stigma that may be attached to becoming a mother is such that it poses a threat to her mental health. This position also would permit an abortion if the female had been forced to submit to the intercourse at which conception took place or had participated in the intercourse prior to the legal age of consent, i.e., legally established forcible or statutory rape. Many physicians may maintain that virtually all circumstances of a pregnancy resulting from statutory or forcible rape or incest pose with the pregnancy and the eventual birth of the child a very real threat to the mental (emotional) well-being of the female and the Pennsylvania Medical Society position would countenance an abortion under those circumstances when three such physicians so agree.

For a contrasting and rather bizarre counter situation, the Pennsylvania Medical Society position would not countenance performing an abortion on a woman for the sole reason that she may prefer to go on a trip to Europe rather than have another child.

Although the Pennsylvania Medical Society position on abortion may be regarded by some persons as being "very conservative", from the above examples it should be evident that it is quite liberal in its definition of medical justification even though it may not

be as liberal as some persons may wish it to be for social reasons.

The Pennsylvania Medical Society is, essentially, a medical organization although the inference should not be drawn that it never makes policy decisions affecting social components. However, in the instance of the abortion position the reasons cited were completely medical and thus are, in the opinion of the Pennsylvania Medical Society, the only justifiable ones for interrupting a pregnancy.